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Student Overseas Elective Reflections

Towards the end of their medical training, students at Queen's University Belfast Medical School are encouraged to undertake overseas medical electives, especially in areas of the world where experience of medical care may be very different from that in the United Kingdom. On return, they are invited to submit reflective essays on their experiences, and these two essays have been chosen as the best submissions for the 2024 round of electives.

Women at the Heart of Tribal Healthcare: A Reflection from a Rural Medical Elective in Southern India

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This summer, I had the privilege of completing my elective placement in Gudalur, a rural town in the Nilgiris region of Tamil Nadu, Southern India. I was based at ASHWINI (Association for Health Welfare in the Nilgiris), a charitable society founded in 1990 to serve the local tribal communities, including the Paniya, Bettakurumba, Mullakurumba and Kattunaykar tribes. ASHWINI's mission centres around empowering these marginalised communities through healthcare, addressing poverty, malnutrition, and disease. It was inspiring to witness how much of ASHWINI's management is now led by members of these tribal communities themselves.[1]

My focus during the elective was on rural medicine, with an emphasis on community healthcare, family medicine, and obstetrics. As a woman in healthcare, I was particularly interested in exploring women's healthcare in tribal settings, eager to understand the care provided to mothers and babies in these populations. During my time at ASHWINI, I encountered diseases rarely seen in the United Kingdom (UK), such as sickle cell disease, leptospirosis, dengue fever, tuberculosis, and malnutrition. My involvement included field visits to tribal villages for antenatal check-ups, mental health assessments, and sickle cell reviews, as well as hands-on clinical practice in the hospital. Working with the obstetrics department, I assisted with ultrasound scans, abdominal exams, and blood sugar monitoring, all of which sharpened my technical skills and deepened my medical knowledge.

During the field visits, I faced a personal challenge in encountering numerous young mothers from the tribal communities, many of whom were younger than myself. Research shows that around 40% of Indian tribal women marry before the age of 18, and many experience their first pregnancy before this.[2] Interacting with these women, I found myself reflecting on how vastly different their lives were from mine, shaped by cultural practices, economic constraints, and limited access to education and healthcare. ASHWINI's ethos of empowering women through healthcare education particularly resonated with me, especially the Health Animator training program, which equips tribal women with basic healthcare skills and knowledge. I felt both fascinated and moved to witness these women, stepping beyond their traditional cultural roles to educate themselves and contribute to their tribe in meaningful ways. This experience compelled me to inspire and support the young women in any way I could.

I contributed to various aspects of female health including breast cancer screening through clinical examinations. I observed a significant lack of awareness and understanding among women regarding the importance of the exams. This highlighted the need for education to remove cultural stigma and raise awareness about preventive healthcare. I also participated in discussions surrounding sickle cell pregnancies, a pressing issue given India's large population of sickle cell patients. Many women had little understanding of the risks associated with sickle cell disease during pregnancy, nor the potential benefits of contraception in mitigating these risks in the future.[3] The need for specialised care, including access to obstetricians and blood banks in these cases, further complicated their situation due to lack of access.

Cultural sensitivity was essential throughout my work. For example, tribal beliefs surrounding the use of tape measures in examinations of the pregnant abdomen and their association with evil spirits, meant alternative palpation methods had to be used. Also, many women were unfamiliar with the date of their last menstrual period, complicating gestation tracking further. In each of these situations, I found myself deeply reflecting on the significant gap in awareness and education that many tribal women have about their own bodies. This lack of understanding not only heightens their risk of various conditions but also delays their seeking medical attention. I was struck by the stark contrast between the level of patient education among the tribal women and the routine awareness of gynaecological screenings that many women in the UK, through the NHS, possess. The

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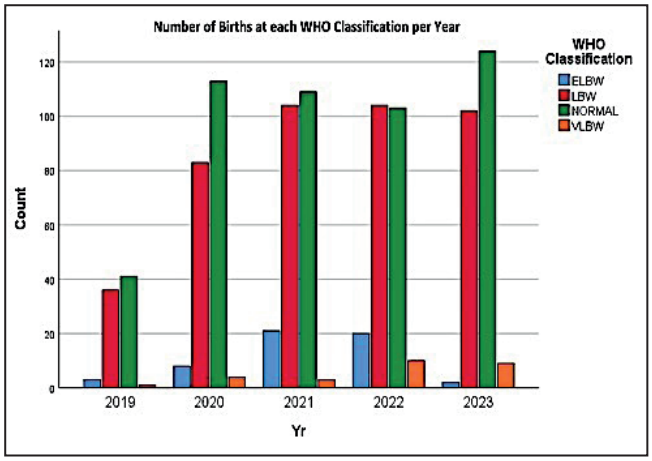
contrast underscored the importance of ASHWINI's role in educating and empowering women about their health.

Reflecting on my role, as a fellow female in healthcare, I took great satisfaction in contributing to the education of other female healthcare professionals at the hospital (Figure 1). Given the significant underrepresentation of tribal women in India's healthcare sector compared to the NHS, I was driven to empower these women.[4] I provided sessions on basic life support and head to toe assessment, adopting the Airway, Breathing, Circulation, Disability, Exposure (ABCDE) technique for student and senior nurses. Supporting the education of these women felt immensely rewarding, knowing that it not only helps them economically but also strengthens their ability to provide critical care in their communities.

Figure 1: Empowering future female healthcare professionals: A teaching moment with young female nursing students in rural India, focusing on practical skills and community care.

Malnutrition, particularly among mothers and new-borns, was another significant issue I observed and was deeply impacted by. This prompted me to delve deeper into this issue, and my research revealed that between 2019 and 2023, nearly 43% of tribal births were classified as low birth weight according to WHO standards (Figure 2).[5] The average birth weight among these tribal populations was 2.44 kg, compared to the global average of 3.3 kg. This stark contrast, especially when compared to the UK average of 3.4 kg, led me to reflect on the complex factors behind this disparity—limited healthcare access, poor maternal nutrition, and cultural practices. ASHWINI is actively addressing these issues through



Percentage of each WHO Classification 2019-2023

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	ELBW	54	5.4	5.4	5.4
	LBW	429	42.9	42.9	48.3
	NORMAL	490	49.0	49.0	97.3
	VLBW	27	2.7	2.7	100.0
	Total	1000	100.0	100.0	

Figure 2: Data provided by ASHWINI research department and analysed personally to create a table and graph showing the annual birth distribution by WHO classification. A breakdown of births categorised under the WHO classification for extremely low birth weight (ELBW), low birth weight (LBW), normal and very low birth weight (VLBW), highlighting trends in maternal and neonatal health between 2019 and 2023, within the tribal community.

https://www.who.int/health-topics/health-workforce#tab=tab_1

maternal nutrition programs and health education, but cultural challenges remain. For example, nutrition provided to mothers is often shared amongst the entire family, diluting its impact. On reflection, the experience of witnessing these challenges first-hand has reinforced my commitment to continuing research and advocacy in maternal and child health. ASHWINI's dedication to addressing these critical issues is truly inspiring, and I am motivated to contribute to this important work in the future.

My elective placement also gave me a deeper understanding of how healthcare in Gudalur differs from the NHS. The hospitals are smaller and more resource-limited, with

restricted access to medical equipment. ASHWINI's approach of bringing healthcare directly to the community contrasts with the more centralised system of the NHS. The ingenuity and adaptability of the healthcare workers in Gudalur were impressive, as they consistently found solutions despite the constraints. This experience has given me a newfound appreciation for the resilience required to deliver quality healthcare under such challenging conditions.

Through field visits and tutorials, I gained insight into how cultural beliefs, socioeconomic factors, and community practices shape health behaviours and access to care. This immersion in a diverse cultural setting enhanced my cultural competence, a skill that has become increasingly important as the NHS becomes more multicultural. Recent data shows that 32% of the NHS workforce now comes from Black, Asian, and Minority Ethnic (BAME) backgrounds, yet challenges persist in achieving equality. [6] My time in India has prompted me to confront any unconscious biases I may have had, reinforcing the importance of culturally sensitive care in all settings.

Reflecting on my elective, I realise it was a transformative experience, both professionally and personally. It expanded my cultural perspectives and significantly enhanced my clinical skills. The dedication of ASHWINI's team to empowering women and improving maternal and child health has deeply inspired me. The resilience of the women I encountered, whether in healthcare roles or tribal communities, has left a lasting impression, strengthening my resolve to advocate for women's health in my future career. The lessons and experiences from this elective will undoubtedly enrich my future medical practice, both in the UK and globally.

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